PRINTED: 08/04/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1912	A. BUILDING 02 - IMPERIAL MANOR CONV/ B. WING _____	08/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IMPERIAL GARDENS HEALTH AND REHABILI	306 W DUE WEST AVE MADISON, TN 37115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 832	1200-8-6-.08(2) Building Standards (2) The condition of the physical plant and the overall nursing home environment must be developed and maintained in such a manner that the safety and well-being of residents are assured. This Rule is not met as evidenced by: Based on observations, it was determined that the facility failed to maintain the nursing home environment. The findings include: Observation on 8/1/11 at 9:34 AM, revealed water stained ceiling tiles throughout the facility. This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 8/1/11.	N 832	N832 Ceiling tiles in various locations in the facility have been replaced on 8/1/2011. The Maintenance Manager will monitor for discolored (water stained) ceiling tiles weekly X 4 then monthly X 3 and will replace tiles when appropriate. (Attachment 15) Results will be sent to the monthly QI Meeting for oversight and further review.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Rose Sharp, Administrator (Interim) TITLE 9/2/11 (X6) DATE

STATE FORM 6899 I25O21 If continuation sheet 1 of 1